California's Health

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PUBLIC HEALTH FORCES MOBILIZED IN REHABILITATION OF FLOOD AREAS

YUBA CITY—SCENE OF DEVASTATION

THE SIGN SAID "MERRY CHRISTMAS"

In the wake of California's pre-Christmas devastating floods, local public health workers in the disaster areas and other local agencies, sided by personnel from neighboring health departments and the State Department of Public Health, have been working around the clock to place water and sewage facilities back into operation, to protect commercial food supplies and to attend to the many other health needs of the flood victims. Notable assistance in the public health rehabilitation work has come from a number of local, state and federal agencies, including the Farm Bureau and Grange, University of California Agriculture Extension, the U.S. Public Health Service, the U.S. Food and Drug Administration, the State and Federal Offices of Civil Defense, the American Red Cross and the U.S. Army Engineers.

The four flood areas of major concern are Humboldt, Santa Cruz, Sutter-Yuba and Tulare Counties. Damage to those areas has been estimated at more than 150 million dollars in property losses alone. In addition to the disruption of water and sewage facilities, and the large-scale contamination of commercial food supplies, there were more than 60 human dead, loss of more than 10,000 head of livestock and untold damage to irrigation systems and crop potentials.

The full report of what has been called California's worst disaster is yet to be written, but in its documentation will appear accounts of heroic efforts during the floods to contain the rampaging waters that threatened even wider destruction and of well-coordinated action to reclaim the flooded areas and rehabilitate flood victims.

(*California's Health* will carry more complete reports in early issues.)

California's civil defense network received its first real test and can be credited with an admirable job of mobilization, coordination and maintenance of vital communications.

In the early hours of the flood crisis, communication was a major problem. The normal media of telephone and teletype lines went out, but the breach was filled by police and highway radio communications, ham radio operators and mobile radio facilities of the Army and Navy. With ground travel cut off, the air lines were quick to offer their help in moving manpower in.

In this disaster, because of the almost miraculously low death and casualty rate, the major emergency public health operations called for have been in the field of environmental sanitation.

First concern of public health personnel was the community water supplies, sewage disposal facilities and the commercial food supply. When these were taken care of and placed on a basis of emergency operation, attention then turned to individual problems—private water wells, family food supplies, disposal of debris, dead

animals and organic material of all sorts. Rats forced from normal habitats by flood waters have posed a problem in some areas where the aftermath of the floods have left harborage and food in unlimited quantities.

With the assistance of the Office of Civil Defense, portable chlorinators were brought into action as a safeguard to public water supplies. Special precautions were also being taken until various sewage treatment plants could be placed back into normal operation.

With laboratory facilities flooded in Tulare County, the Fresno County Health Department offered their laboratory services. The Tulare services were resumed after about 10 days.

Commercial food stocks suspected of contamination were placed under quarantine pending inspection and clearance for use or orders to destroy. Canned goods were the only commercial foods salvagable in stores and warehouses where stocks were inundated. Food supplies deemed unsafe were hauled to dump areas for disposal, posing a problem for disposal crews in some instances where people attempted to pick these foods up.

Householders were advised on precautions to take with respect to their own food suspected of contamination, and, in general, were warned to boil all drinking water from wells suspected of contamination. The State Department of Public Health sent two mobile laboratories and personnel into the flood areas to check water supplies and perform other laboratory work, as well as to aid local personnel in the job of instructing persons on how to disinfect their water systems and salvage family food supplies.

It is not believed that any epidemics will occur, principally because of the speed in which persons were evacuated from the flooded areas, and also because of the prompt action of local health departments with respect to water and food. Public health nurses were assigned to some areas to assist in programs of disease prevention and immunization.

The department, upon request, shipped 24,000 cc's of typhoid vaccine into the flood areas, as well as supplies of needles, syringes and other medical equipment. The Tulare County and Sutter-Yuba County Health Departments have urged all persons in constant contact with flood waters to be vaccinated against typhoid.

A notable aspect of the emergency manpower situation was the immediate application of the principle of mutual assistance. Local health departments throughout the state were quick to offer assistance, with Oakland City, Fresno and Los Angeles County Health Departments among the first. Public health personnel—sanitariums and public health nurses—were made available by the boards of supervisors in the neighboring counties of Los Angeles, Kern, Fresno, Placer, Shasta and Butte. The State Department of Public Health assigned nearly 100 personnel to the four flood areas, including engineers, food and drug inspectors, vector control personnel, laboratory technicians, public health nurses, and medical officers. The U. S. Food and Drug Administration assigned food and drug inspectors and the U. S. Public Health Service sent public health engineers into the Santa Cruz, Humboldt and Sutter-Yuba areas.

Work of the state health staff in the field has been coordinated through an emergency flood relief control center in the department. This control center is working in close liaison with Dr. Frank L. Cole, Chief, Division of Civil Defense, Medical and Health Services.

Public Health Positions

Butte County

Director of Public Health Nursing: Salary range, $436-$513. Generalized nursing program, including school program. Field training agency for new state college nursing school. County car or 8 cents per mile. For further information write Garold L. Faber, M.D., Director, Butte County Health Department, P. O. Box 110, Chico.

Contra Costa County

Public Health Nurse: Salary range, $357-$429. Advance to $374 at completion of probation period. Final filing date, February 17. Requires California Public Health Nurse Certificate. After nine months with Contra Costa County and a total of two years experience as a public health nurse, appointees are eligible to advance to Senior Public Health Nurse with a beginning salary of $392.

Physical Therapist and Occupational Therapist: Salary range, $357-$429. Advancement to $374 after six months probation period ends. Physical therapist position requires graduation from a recognized school of physical therapy, and occupational therapists must have national registration or eligibility for such registration.

Clinical Laboratory Technician: Salary range $341-$410. Advance to $357 after six months probation. Requires California Clinical Laboratory Technician Certificate.

Applications and additional information on Contra Costa positions may be obtained from Civil Service Department, Room 229, Hall of Records, Martinez.

San Diego County

Public Health Engineers: San Diego County offers permanent position as consultant on engineering phases of public practices and problems. Applicants must be college graduates experienced in public health engineering and registered in California as civil engineers. For details write Civil Service, Room 402, Civic Center, San Diego.

Sanitarians: Salary range, $378-$417. Applicants must have California registration. (Trainee positions leading into work as professional registered sanitarians are available. Salary range, $327-$360. Age 21-34. Written examination may be given in student's locality before graduation. Bachelor's degree from accredited college with major in biological, chemical or physical sciences required before employment.) For further information write County Civil Service, Room 402, Civic Center, San Diego.

San Bernardino County

Assistant Director of Public Health: Salary $866. Must possess license to practice medicine in California.

Public Health Nurse: Salary range, $360-$438, for desert areas, $378 to start. Requires valid California certificate of registration as a public health nurse.

Medical Social Worker-Consultant: Salary range, $360-$438. Requires completion of a two-year postgraduate course in an accredited school of social work and one year of full-time paid experience in medical social work.

For further information on San Bernardino County positions write County Personnel Department, 236 Third Street, San Bernardino.

San Joaquin Local Health District

Public Health Nurses: Staff increased from 24 to 30. Salary range, $335-$420.

Registered Sanitarian: Salary range, $335-$420.

Consultant in Health Education: Salary range, $395-$500.

All positions are covered by merit system. Transportation furnished. Starting salary above the first step for those with satisfactory experience. For further information write E. M. Bingham, M.D., District Health Officer, P. O. Box 2009, Stockton.

Stanislaus County

Health Officer; Stanislaus County Department of Health: Salary, $877-$1,000. County retirement plan. Write Mr. Ed. Hane, Stanislaus County Administrator, Modesto.

City of Vernon

Sanitarian: Salary range, $375-$440. Requires bachelor's degree in sanitary or allied science and registration as a sanitarian in California. Prefer individual with industrial and environmental sanitation experience. Car allowance. Write Robert S. Stone, Director of Sanitation, 4305 Santa Fe Avenue, Vernon 58.

WORKING WITH PEOPLE OF DIFFERENT CULTURAL BACKGROUNDS *

GEORGE M. FOSTER, Ph.D., *Professor of Anthropology, University of California, Berkeley*

Our period in history is marked by the firm belief that citizens working within a democratic framework can recognize imperfections in their societies and through careful planning and group action work toward the correction of these imperfections. The recognized imperfection that brings us together today is an average national level of health not commensurate with our medical knowledge and our wealth. That is, higher health levels than actually prevail are technically and economically possible in the United States.

Part of the problem, we know, is educational; people must understand what personal hygiene, environmental sanitation, and proper medical care mean to them in terms of better health. And part of the problem is motivational; people must want to take necessary steps which they know lead to better health. Both education and the study of motivations with a view to implementing health programs imply individual and group changes in beliefs, attitudes, and behavior. The beliefs held by people about the nature of disease and health, their attitudes with respect to what one does in time of illness or to maintain health, and the actual health behavior that marks their lives, must in some degree be modified if significant advances in health levels are to result.

Experience shows that when health personnel—doctors, nurses, health educators, sanitarians, etc.—work with people of their own general social and economic background they accomplish more. In part this is because they are able to "communicate" more effectively. Practitioner and patient, to use the terms in the broadest sense, are able to understand the nature of the problem and each other with a minimum of difficulty. As differences in social and economic backgrounds become more pronounced, patient and practitioner have greater and greater difficulty in "communicating," in understanding what the other person wishes or is trying to do. Communication difficulties mean much more than simple language differences; they stem from the very different premises on which the outlook and understanding of people of diverse backgrounds are based.

Social Science Concepts

Recent developments in the social sciences have shed light on these communication problems, and an understanding of their nature promises to facilitate public health work, especially in situations where recipients of services are members of minority groups marked by distinct ethnic origins. I find that the social science concepts of "culture," "status" and "role" are especially helpful in elucidating these problems. "Culture," I am sure you all know, refers to the common way of life shared by the members of a society. It includes the totality of tools, techniques, social institutions, attitudes, beliefs, motivations, goals, values and so forth which prevail with a particular group of people.

Perhaps the concept of culture will be most helpful, in the sense I am using it here, when understood as the more or less standardized behavior of the members of a society. We, as members of a group, are marked by particular behavior forms, and we understand them, by virtue of having been born into the group, and having learned them in the course of growing to maturity. As members of a society who have learned the behavior forms that constitute a particular culture, we are able to carry on our activities in cooperation with other members of our culture, in a way that would be impossible if we did not share a common culture.

Social "Cues"

An important function of our culture is to supply us with the tips or leads or, to use the sociologist's term, the "cues" that enable us, in any social situation where we are interacting with other people, to understand and anticipate the behavior of other individuals, and in turn to know how to behave ourselves. To take a simple illustration, as California adults we frequently purchase food, occasionally buy clothing, sometimes buy an automobile, and perhaps once or more times during our lives, a home. In all cases we are "buyers," spenders of money, but our behavior will be quite different in each situation, as will that of the seller. In the first case we immediately pay the asking price without question, and take the product as it is. In the second case we also pay the asking price, but perhaps insist on certain alterations as a part of the bargain, and reserve the right to pay a few days or weeks later. In the third case we would not think of paying the asking price, and probably we will insist on buying only if the seller will take a part of the price in kind. In the last case we also will not pay the asking price—in fact we know the seller does not expect us to; and we may reasonably plan to defer part of the payment for many years.

The behavior of buyer or seller that is appropriate to any one of these situations would appear ridiculous in any of the others. But since both have learned the same "rules of the game" as members of the same culture, each transaction need not be preceded by lengthy discussion to establish common meeting ground.

"Status" and "Role"

The sense of the above paragraph is perhaps made more clear by the sociologist's concepts of "status" and "role." "Status," I hardly need to say, refers to the positions or places of an individual in his society; not simply his social position, but all of the positions he may occupy from time to time, such as child, parent, buyer, seller, boss, worker, health educator, professor, club president, and so on. "Role" refers to the sum total of behavior patterns, including attitudes, values, and expectations, associated with a particular status. For example, the status of father in American society correlates with a particular role exemplified in more or less stereotyped behavior forms toward his children. Allowing for great individual differences, the American child learns to expect certain forms of behavior on the part of his father that are vastly different from the paternal behavior a Hopi child learns to expect. Conversely, the American child soon

* A digest of a presentation to the Health Education Workshop, Asilomar, 1955.

learns general forms of filial behavior that his culture tells the father he may expect from his offspring.

All of us, in the course of the day, occupy a series of statuses for which we have learned the proper role, the customary behavior patterns. When we know the behavior expected of us by our culture for each status we occupy, and the behavior associated with the statuses of the people with whom we interact, we achieve a psychological security otherwise unobtainable. We feel at home in the situation, we can pretty well predict what we are going to do, and we know in a general way how others will respond to our actions. It is this ability to know how to act, and to predict how others will act, that makes it possible for people of the same culture to function together to understand each other.

Cultures Are Not Static

No culture can be a completely satisfactory device for preparing people to live together. One difficulty is that cultures are not static; they change continually, slowly or rapidly. New ideas most often come from outside a culture, via borrowing, but some are developments from within. Sometimes changes are spontaneous, without conscious design or plan; on other occasions they result from recognition of needs, and the belief that something can and should be done to change the status quo.

Public health programs clearly fall into the second category. But in either case one result is that stereotyped behavior of a particular role will gradually change as the nature of the role changes. Consequently, in a rapidly changing culture it is difficult for all individuals to adjust the behavior that constitutes their customary roles at exactly the same speed. To illustrate, the past generation has seen many changes in the expected role of parents and children in American culture. The behavior patterns for children and parents we learned in childhood are only partially useful in 1955. As parents we must continually adjust our attitudes, make concessions, and tolerate behavior unacceptable in our childhood, if we are to avoid complete frustration and breakdown.

If this is true for us members of American society, think of the problem of the individual from a completely different culture who is suddenly plunged into American life. The immigrant father, for example, usually feels his role requires authoritarian attitudes toward his children which are at variance with American practice. He expects obedience and respect normally absent in today's children. He has not had a generation to modify his thinking, as have we, and when the behavior of his children, conditioned by that of their school mates, does not conform to his expectations, his security is threatened and he functions less effectively as a father than might be desired.

Concepts Applied to Medicine

Now let us apply these concepts to medicine, using the term in the broad sense of all practices and beliefs associated with health and its maintenance and illness and its treatment. Medicine, in this sense, constitutes a major segment of our culture. To quote Saunders, "In its totality medicine consists of a vast complex of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals, and symbols, that interlock to form a mutually reinforcing and supporting system."[1] Moreover, the practice of medicine is an activity in which people participate in large measure on the basis of learned cultural norms. Again quoting Saunders, "In whatever form it may take and wherever it may occur, the practice of medicine always involves interaction between two or more socially conditioned human beings. Furthermore it takes place within a social system that defines the roles of the participants, specifies the kinds of behavior appropriate to each of those roles, and provides the sets of values in terms of which the participants are motivated."[2]

That is, whether we are dealing with physician and patient, public health nurse and mother, or health educator and audience, there are at least two individuals who are interacting with each other. To a very great extent the success of this interaction reflects the extent to which the participants have learned the behavior and expectation patterns of the several roles within the institution. The physician in our culture expects the patient to listen carefully and answer his questions, to have confidence in his judgment, and to carry out the treatment he prescribes. The patient in turn expects certain things from the physician: that the physician be well trained, observe a high code of ethics, be able to diagnose the case and prescribe treatment that will restore him to health, and so forth. Institutionalized forms of learned behavior, rather than individual personalities, are instrumental in setting the pattern of such relationships, and making them effective.

Medical Roles Change Too

Medical roles, like family roles, change with the years, and differential rates of understanding and adjustment to these changes will influence adversely the degree of communication present and consequently the outcome of the activity. The elderly person from a small town, who conceives of physician-patient roles in terms of the family physician-general practitioner will find the impersonality of the specialized city clinic a frustrating and unsatisfactory answer to his medical needs; communication, as he understands the concept, will be largely absent. Continuing the analogy given above of father and children, it is clear that communication problems will be even greater when medical personnel activities and health concepts of one culture are brought to bear upon people of radically different cultures. People, generally have very specific ideas about health and illness, and about disease causation and treatment. Whether these ideas are scientifically based, as we feel ours are, or whether they are based on what we consider superstition, human beings everywhere are emotionally attached to them, and passionately believe they are correct.

Included in these ideas are the expectations the layman holds with respect to members of the medical profession; that is, the layman has a strong idea as to how the curer should comport himself. In India, for example, regardless of what the curer really believes, he must assure patient and family by saying "He is going to be all right; he is going to get well." Perhaps the patient will be dead in

[1] Lyle Saunders, *Cultural Difference and Medical Care*. Russell Sage Foundation, New York, 1954, p. 7.
[2] *Ibid.*, p. 7.

half an hour, and perhaps the family also knows this. Nevertheless the ritual words must be spoken. They prove to the family that the doctor knows his business, that he is professionally competent. A physician from another culture, however skilled he might be, who would advise the family to prepare for the inevitable would find few patients.

Latin American Culture

Similarly, in Latin America a folk curer frequently divines the nature of an illness by looking into the patients eyes, feeling his pulse, or even going into a trance. He asks few or no questions. The patient has called upon him to be told what is wrong by a specialist, and he doesn't expect to tell the specialist what is wrong. Both patient and curer have role expectations vastly different from those encountered in an American medical interview. When such a patient is confronted by an American physician, when he is asked, "What are your symptoms?" "Where does it hurt?" "How long have you felt this way?" and so on, he loses confidence, because this is not what he, the patient, expects from a curer. He is convinced the physician is a fraud; why should a person who claims to know how to cure ask the patient what the matter is? The American physician, on the other hand, is puzzled and annoyed at the uncooperativeness of his patient, and perhaps concludes that the reason is stupidity. Both participants are affecting the behavior they believe appropriate to the situation, and misunderstanding is complete.

These instances illustrate a general proposition: when medical practice involves individuals from different cultures, what is done or attempted by those in the healing role may not be fully understood nor correctly interpreted by those in the patient role; conversely, the responses of those in the patient role may not conform to the expectations of those in the healing role. Ideally, greater understanding of the social nature of the healer-patient relationship by both medical personnel and clients is desirable. In practice it is clear that this understanding must come, in most cases, from the medical professional. Experience shows that when persons of different cultures are involved in a medical relationship the goal of this relationship is more nearly achieved: (a) when the healer is aware of the cultural premises upon which he operates, and particularly when he grasps the significance of his culturally conditioned role and role expectations; and, (b) when he knows something of the cultural premises and role expectations brought into the relationship by the patient.

Importance of Understanding

The importance of understanding cultural premises, the nature of communication, and the meaning of role and role expectation in order to facilitate public health work among people of different cultural backgrounds in the United States may be illustrated by examples drawn from Latin American culture.

(1) The concept of "maintenance." The importance of greasing an automobile at regular intervals, of painting a home every few years, of periodic checkups with a physician, are understood by most of us. From childhood our proverbs complement our formal teaching, and "A stitch in time saves nine" is taken as self-evident. Probably for this reason preventive medicine, which implies maintenance of the human system, is reasonably effective in our country. In Latin America the idea of maintenance is far less developed. If a machine runs well, obviously it needs no attention: the time to do something is when it stops running. The same philosophy generally characterizes attitudes toward health. Time after time I have been told by informants, "If I feel well, obviously I am well. Why should I do anything until I feel ill? I need the doctor when I am not well." Obviously in this setting a program of preventive medicine will meet with indifferent success, and experience has show that American-style public health programs often must be tempered with curative services. When such people move to the United States it is likewise obvious that their attitudes toward routine public health programs will not make for the highest degree of understanding and cooperation.

(2) The concept of "folk medicine." Much illness in Latin America is explained in what we would consider to be nonrational terms. Magic, witchcraft, supernatural agencies, the "evil eye" and the like are thought to cause illness. Almost any adult can give names of half a dozen or more "illnesses" resulting from such causes, "illnesses" with real clinical symptoms. Folk medicine likewise specifies the treatment, either of folk curers or by home remedies, that are appropriate for each. Treatment that seems to follow what patient and family expect is reassuring; strange treatments are difficult to understand. When a mother takes an ailing child whom she believes to be afflicted with "evil eye" to a physician who scoffs, who assures her there is no such thing, she loses confidence. The child obviously is ill; why risk his life with a physician who denies the very existence of the illness? Next time the child does not see a physician.

In Latin America my colleagues and I have noted cases in which public health nurses have found seriously ill children at home; the mothers had diagnosed the case in folk terms, and knowing physicians denied such causes, they preferred to seek other remedies. The moral to be drawn from such instances is, when working with people from a different culture, don't ridicule their beliefs; don't poke fun at them. It is possible to work effectively with people without forcing them to give up immediately the beliefs they have held since childhood.

(3) Social classes. Social classes are more rigid in Latin America than in the United States, and antagonism toward and distrust of the motives of members of other classes are widespread. Since most medical personnel come from the upper classes, and most patients in a public health context come from the lower classes, serious tensions beyond those normal to a therapeutic setting are found. Health personnel often doubt the intelligence of their patients, and patients are dubious as to the motives of health personnel. Often embarrassment and confusion so mark a low class person's behavior in the presence of a high class person that the patient literally is unable to hear what he is being told. Moreover, lower class Latin Americans often distrust the motives of government officials. So, the American public health worker in a Latin American sector must overcome two non-

medical barriers before working rapport is established: that stemming from differences in social class, and that due to his official status.

(4) The importance of "face." Latin Americans are characterized by a feeling of personal dignity that is much like the Chinese concept of "face." Affronts to dignity cause loss of face. Lack of understanding across cultural boundaries as to what may cause loss of face may hinder the work of American health personnel. In our culture a doctor or a nurse is expected at times to be jocular with the patient, perhaps to scold him a bit for not having complied perfectly with instructions. In this context the physician's words "You're really an awful patient to work with" would not be out of order. Yet this same behavior exhibited toward an individual from a culture where personal dignity is of highest importance, where doctors normally would not jest in this way, might cause humiliation and anger, and a breakdown in an otherwise effective working relationship. It is well to remember that in working with Latin Americans—and members of many other cultures as well—American forms of humor and banter are apt to backfire.

Summary

In working with people of different cultural backgrounds from one's own there is no single set of rules that makes for success. Patience, sympathy, and understanding are basic. Beyond this, awareness of the nature of one's own role, and knowledge of enough of the other person's culture so that his concept of role behavior can be grasped, have been found to be useful in promoting effective work.

Home Canned Olives Blamed For Botulism Death

Three Los Angeles residents became ill and one died recently following ingestion of a meal which included home canned olives, later found by laboratory tests to contain botulinus toxin (type B). The olives, stored in two-gallon sealed glass containers, had been prepared about a year ago. Improper preparation and exclusion of air permitted the botulinus toxin to form.

State Board Issues Quarantine On Portions of San Diego Bay

At its December meeting the State Board of Public Health established a quarantine along the Coronado shores of San Diego Bay "against all recreational use and other uses involving body contact with bay waters." The action was taken on the basis of studies made last summer by the State Department of Public Health at the request of the San Diego Health Department. The studies showed "excessive counts of coliform organisms in bay waters and presence of raw sewage solids along the shores of the bay in the vicinity of the two raw sewage discharges from the City of Coronado."

The quarantine area included the shoreline generally paralleling First Street in Coronado, from the city limits at North Island to the easterly point in the public housing area. The order requires that the public be excluded from the shore waters and the beach in the quarantine zone. The San Diego Health Department and the City of Coronado have been directed by the board to post warning signs to the public and enforce provisions of the quarantine.

The board also ordered warning signs posted along the north shoreline of San Diego and National City, calling for exclusion of the public.

The board has notified the city councils of San Diego, Coronado, National City, Chula Vista and La Mesa, which border San Diego Bay, the governing boards of the Sanitation Districts of Lemon Grove, Rolando, and the Eleventh Naval District, calling for prompt action in correcting the existing "hazardous and offensive condition in San Diego Bay waters due to discharge of sewage and sewage effluents; warning of the ever increasing magnitude of the problem due to population growth. . . ."

The board also gave attention to potential public health hazards at White's Point in San Pedro Bay and in the waters of the Los Angeles outer harbor along the south shoreline of Terminal Island from the entrance channel on the west to Reeves Field Naval Reservation on the east. Continued studies of these areas were requested by the board.

Mrs. Bevil Named Vice President Of State Board of Public Health

Filling an office left vacant by the death November 30th of Dr. James F. Rinehart of San Francisco, Mrs. P. D. Bevil, of Sacramento, has been elected Vice President of the State Board of

MRS. P. D. BEVIL

Public Health by her fellow board members. The election took place at the December 9th meeting of the board in Santa Ana. Dr. Charles E. Smith, Dean of the U. C. School of Public Health, Berkeley, is president of the board.

Mrs. Bevil, a past president of the California Congress of Parents and Teachers, is serving her first term with the board. She was appointed January 15, 1954, by Governor Goodwin J. Knight to serve a three-year term ending January 15, 1957. Her appointment came when the board was enlarged from seven to nine members in accordance with a legislative amendment enacted during the 1953 Session.

Registration Examination Scheduled for Sanitarians

An examination for registration as a sanitarian in California will be held February 15th in Berkeley and Los Angeles. February 1st is the final date for filing application with the Bureau of Sanitary Engineering, State Department of Public Health, 2151 Berkeley Way, Berkeley 4.

State Board of Education Revises Health and Development Credential

On October 6, 1955, the California State Board of Education adopted a revision of the requirements of the health and development credential for all classifications of health personnel serving the schools. The new requirements become effective September 15, 1956. No one now serving on a regular health and development credential will be affected by the change in requirements unless the present credential reaches its expiration date and the individual fails to renew it.

One change in requirements was the deletion of the requirement of two years experience, in their respective fields, for physicians, dentists, psychiatrists, occulists, otologists, optometrists, dental hygienists, chiropodists and audiometrists. In order to obtain a health and development credential after September 15, 1956, the above-mentioned health personnel must possess a valid license to practice in their respective service fields in California and must submit the regular application forms for a credential.

Other changes were specifically related to credential requirements for school nurses. After September 15, 1956, there will be two methods by which a school nurse may become qualified for a health and development credential:

1. The possession of a valid certificate of public health nursing issued by the California State Board of Public Health.
2. The possession of a bachelor's degree granted by an institution accepted for credentialing purposes by the California State Board of Education *or* verification of three years of satisfactory full-time service as a school nurse in the schools of California within the five-year period immediately prior to September 15, 1957, *and* in either case (bachelor's degree or experience) 36 semester hours acceptable preparation, for which college credit has been granted, covering each of 10 areas specified in the credential.

Copies of revised requirements for the credential have been distributed to all local school districts and to local health departments. Individuals wishing a copy of the requirements may obtain them from the Credentials Office, State Department of Education, 721 Capitol Avenue, Sacramento 14.

The Credentials Office will be glad to assist nurses with an evaluation of their present training in terms of the revised requirements. Such requests should be accompanied by official transcripts of all post-high school work and should be sent to the Credentials Office. Requests for evaluation should be made as soon as possible as the volume of work in the Credentials Office greatly increases during the spring and summer months. At least six weeks should be allowed for the evaluation process.

The revised requirements for the credential were based to a great extent on two studies of the preparation, functions and responsibilities of nurses serving the schools of California. One study was conducted by Dr. Jerome Grossman, formerly Associate in Public Health, School of Public Health, University of California, and the other by the California State Department of Education. Description of the studies and a summary of findings will appear in a State Department of Education Bulletin now in the process of preparation. When completed the bulletin will be distributed to local school districts and local health departments.

Rabies Endemic Areas Declared In Three More Counties

Orange, Santa Cruz and Tuolumne Counties have been officially declared rabies endemic areas by the State Department of Public Health as the result of recognized cases of animal rabies. Thirty-two of the State's 58 counties have now been declared rabies endemic areas as a result of rabies being reported since January 1, 1955.

California's total of recognized rabies cases for 1955 stands at 416, of which 241 have been dogs, 9 cows, 1 goat, 3 cats, 19 foxes, 139 skunks, 1 raccoon and 2 bats.

In the calendar year 1954, there were only 83 cases of rabies reported in California, of which 43 were among wildlife and 33 in dogs. They included 33 dogs, 1 cat, 4 cows, 1 horse, 1 sheep, 2 bobcats, 8 foxes, 1 raccoon, and 32 skunks.

In the rabies outbreak that prompted Orange County to be declared an endemic area, rabies in 11 dogs and 1 cat has been reported. In view of this, the Orange County Board of Supervisors and 10 of the county's 14 cities had passed compulsory dog vaccination ordinances as of January 4th. One additional city has had an ordinance in effect since 1952. The four remaining incorporated areas are expected to enact ordinances within a week.

Rabid skunks were reported from Santa Cruz and from Tuolumne Counties.

Some 30 counties and cities already have declared quarantines or animal control ordinances and similar laws are pending or are under consideration by many other local governing agencies.

Counties which have been declared endemic are: Alameda, Amador, Butte, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Humboldt, Lake, Los Angeles, Marin, Mendocino, Merced, Monterey, Napa, Orange, Placer, Sacramento, San Benito, San Joaquin, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Ventura, and Yolo.

Bat Rabies

During the period from June, 1953, to date, a total of 93 bat rabies cases has been reported. These infected bats have been collected in California, Florida, Louisiana, Montana, New Mexico, Ohio, Pennsylvania, and Texas. Four species of free-living and eight species of colonial or cave-dwelling bats have been implicated so far. The greatest number of rabies virus isolations has been made from Mexican freetail species which were collected in southwestern United States. Three of the 93 isolations have been associated with episodes involving the biting of human beings—1 in Florida (Florida yellow bat), 1 in Pennsylvania (hoary bat), and 1 in California (Mexican freetail bat). — *Morbidity and Mortality Report of National Office of Vital Statistics,* November 14, 1955.

Popcorn Dye Suspected as Cause Of Food Poisoning Outbreak

Some 50 children of employees' families attending a Christmas party at an industrial plant in Contra Costa County became ill four to six hours after eating orange colored popcorn. Investigation indicated that the dye used in coloring the popcorn was apparently the responsible agent, since children eating candy but no popcorn did not become ill. Laboratory tests are pending.

Investigation further revealed that the dye used in coloring the popcorn had been banned from use by the U. S. Food and Drug Administration as of November 16, 1955, but the order does not become effective until 90 days from that date. It was reported that the plant from which the popcorn was obtained had used this dye previously with similar reports of cases. The illness was characterized by headache and vomiting. After vomiting from one-half to four hours, the children usually felt well enough to go back to sleep.

Man is menaced by more than 80 diseases—known as zoonoses—which afflict both wild and domesticated animals and are passed on from them to people.—*W. H. O. Newsletter*, Vol. 8, No. 11-12.

Review of Reported Communicable Diseases Morbidity by Month of Report November, 1955

Diseases with Incidence Exceeding the Five-year Median

Diseases	*Nov. 1955*	*Nov. 1954*	*Nov. 1953*	*Five-year median*
Amebiasis	47	54	24	43
*Coccidioidomycosis	29	8	4	5
Diphtheria	11	6	1	6
Hepatitis, infectious, including serum hepatitis	204	149	113	113
Measles	1,220	736	963	736
Mumps	3,570	1,626	1,814	1,626
Rabies, animal	56	4	16	4
Salmonella	97	65	51	39
Shigellosis	253	114	109	92
Typhoid fever	9	8	4	7

Diseases Below the Five-year Median

Diseases	*Nov. 1955*	*Nov. 1954*	*Nov. 1953*	*Five-year median*
Brucellosis	4	5	1	11
Encephalitis, type undetermined	17	21	8	17
Food poisoning	10	325	217	87
Malaria	2	2	4	4
Meningitis	20	24	27	24
Pertussis	221	438	113	263
Poliomyelitis (total)	292	286	409	406
Poliomyelitis (paralytic)	181	186	258	307
Strep. infections, including scarlet fever	480	498	537	537
Tetanus	2	5	2	5

Venereal Diseases

Diseases	*Nov. 1955*	*Nov. 1954*	*Nov. 1953*	*Five-year median*
Syphilis	711	478	445	530
Gonococcal infections	1,425	1,134	1,162	1,162
Chancroid	11	6	8	[1]
Granuloma Inguinale	1	--	1	[1]
Lymphogranuloma venereum	3	1	4	[1]

[1] Median not calculated.
* Prior to July 1 only disseminated form was reportable.

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